PRINTED: 07/12/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	(X2) MULTIPLE ( A. BUILDING B. WING	00	COM 06/1	E SURVEY PLETED 4/2013		
	PROVIDER OR SUPPLIE	R	211 W	ADDRESS, CITY, STATE, ZIP CO	DDE			
IN-PACT	INC		MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
W000000								
			*************					
			W000000					
		or a fundamental						
	recertification as	nd state licensure survey.						
	Dates of survey:	: June 10, 11, 12, and 14,						
	2013.							
	Facility number	: 001018						
	Provider numbe							
	AIM number: 1							
		00237010						
	Surveyor: Amb	or Place OIDD						
	Surveyor. Aino	el Bioss, QIDF						
	The Callessies C	- damat da Caiamaia a ataa						
	_	ederal deficiencies also						
		lings in accordance with						
	460 IAC 9.							
		mpleted 6/25/13 by Ruth						
	Shackelford, QIDP							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001018

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE:		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
		15G504	B. WING		06/14/2013
NAME OF D	DOVIDED OD SUDDIJEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF		211 W	76TH AVE	
IN-PACT	INC		MERRILLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG W000149	483.420(d)(1) STAFF TREATM The facility must written policies an mistreatment, ne  Based on intervi facility failed to policies and prod abuse in regards against a client f (Client #3). The written policies a local police depa substantiated alli #3). The facility policy on abuse prohibition in re with the potentia living in the grou #3, #4). The fac policy to ensure origin were repo administrator an for 1 of 1 injury of 3 sampled clie  Findings include  1. On 6/10/13 a (Bureau of Deve	gards to Elder Justice Act al to affect 4 of 4 clients up home (Clients #1, #2, ility failed to follow their all injuries of unknown red immediately to the d thoroughly investigated of unknown origin for 1 ents (Client #3).	W000149	Policies and procedures are written, in place and implemer prohibit abuse to clients. All st are trained on abuse/neglect a reporting policy upon hire and least annually thereafter. Responsible person: Ruth Fie Training Coordinator.A staff meeting was held following thi incident. We discussed indicators, responsibilities, good care practices by knowing the clien needs, wants and interests. Walso discussed problem solvin anger mgt, coping strategies; well as to focus on the cause verses the aggressor at to have a better understanding the disability. Responsible persons: Sheila O'Dell, Group Home Director, Traci Hardesty QMRP & Karen Warner, behaviorist. A protocol was als put into place for Client #3 and trained on following this incide Responsible persons: Sheila O'Dell, Group Home Director, Traci Hardesty, QMRP & Karen Warner, behaviorist. The policy would have been contacted w 24 hours per the Elder Justice Act, but the family came over evening and called. Not more	aff and at  dds, s  t's e g, as as ad g of  /, so d int.
	5/22/13 indicate	A BDDS report dated d on 5/21/13 Client #3		than one person needs to report the same incident. Responsible	e
	was "agitated be	cause he lost his outing		person: Traci Hardesty, QMRI	·

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G504	B. WING		06/14/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	CR.		76TH AVE	
IN-PACT	INC			ILLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	per his behavior	r plan." The report		The Elder Justice Act is poste	
	indicated Client	t #3 went into the living		all locations in common area i	
	room and begar	"messing with the TV, as		view. Responsible person: Ing Stringer-Bullard, Group Home	
		to knock it over." The		Manager.QMRP, Manager an	
		DSP (Direct Service		staff will be re-trained on police	
	•	and two other staff went		#28 reporting and investigatin	·
	· · · · · · · · · · · · · · · · · · ·	oom to attempt to redirect		incidents of abuse, which	
	1	*		includes reported injuries of	
		report indicated DSP #1		unknown origin	
		ve the TV alone. [Client		immediately. Responsible per Sheila O'Dell, Group Home	son:
		P #1] in the knee and		Director. To ensure future	
	[DSP #1] lost h	er temper." The report		compliance, the training	
	indicated anoth	er staff attempted to move		document will specifically state	e
	Client #3 out of	Tthe way but DSP #1		the Elder Justice Act to show	
	"pushed [Client	: #3] and the other staff to		initial and continuing training t	
	the couch. [DS	P #1] hit [Client #3] in the		employees. Responsible pers Ruth Fields, Training Coordinate	
	-	Client #3] spit in her face.		To ensure future compliance,	
	_	ed [Client #3]'s face and		policy on reporting and	
		The report indicated three		investigating incidents was	
	1 *	and "got [DSP #1] off of		revised to state the Elder Just	
		he report indicated DSP		Act, so that they would not be	any
		•		confusion on when to call the police. Responsible person: R	uth
		quitting her job and left		Fields, Training Coordinator.	
	the group home			ensure future compliance,	-
				reliabilities will be completed t	o
	_	ort indicated Client #3		ensure competency. Respons	
		oody nose and lip along		person: Traci Hardest, QMRP	
	with scratches of	•		and Ingrid Stringer-Bullard, Gill Home Manager.	roup
	shoulder/collarl	oone area." The report		Home Manager.	
	indicated Client	t #3's parents were			
	informed and cl	hose to file a police report.			
		cated DSP #1 was			
	_	ling investigation and was			
		n the allegation of abuse			
	was substantiate	_			
	was substantiati	cu.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETI	ED
		15G504	B. WIN			06/14/20	13
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .		211 W 7	76TH AVE		
IN-PACT					LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIACI )		DATE
		n was reviewed on					
		AM and indicated all					
	_	ing the 5/21/13 incident					
		#3 were interviewed.					
	_	n indicated the QIDP					
	` ~	ectual Disabilities					
	,	is in the home during the					
	incident and pro	vided a written statement.					
	The investigation	n indicated DSP #2					
	provided a writte	en statement on 5/22/13.					
	DSP #2 indicate	d DSP #2 attempted to					
	intervene betwee	en Client #3 and DSP #1.					
	DSP #2 indicate	d all three of them (DSP					
	#1, DSP #2, and	Client #3) fell back onto					
		#2 indicated Client #3					
	kicked DSP #1 i	n the knee. DSP #2					
		1 held Client #3's face					
		nd while DSP #2 tried to					
		'lient #3 spit in DSP #1's					
	_	dicated DSP #1 asked					
		did you spit on me?"					
		d DSP #1 "began to push					
		with a (sic) open hand."					
		d Client #3 was struck					
		es and was "bleeding					
		· ·					
	from his nose an	u moum.					
	The investigation	n indicated DSP #3					
	_	en statement on 5/22/13.					
	1 *	d Client #3 kicked DSP					
		DSP #3 stated DSP #1					
		n his face with her fist.					
	[Client #3's] nos	e and lip was (sic)					

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	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		LDING	NSTRUCTION 00	(X3) DATE COMPL <b>06/14</b> /	ETED
NAME OF F	PROVIDER OR SUPPLIER		<b>P</b> . (12)	STREET A 211 W 7	ODDRESS, CITY, STATE, ZIP CODE 76TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) #3 indicated Client #3		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	spit on DSP #1 a the face and Clie	nd she grabbed him by ent #3 sustained scratches of his face as a result.					
	5/22/13. DSP #4 kitchen as the ind DSP #4 indicated up in the living r the room. DSP # to pull her out of she said 'I quit the DSP #1 gave a w	ritten statement dated					
	agitated over los behavior of "wet indicated Client said he intended indicated Client back inside and in break the televist she was alone we room when she is indicated Client him down falling indicated Client at her. DSP #1 is over Client #3's is spitting. DSP #1 up from the couc	indicated Client #3 was ing his outing due to his ting the bed." DSP #1 #3 began cursing and he to run away. DSP #1 #3 went outside but came indicated he intended to ion. DSP #1 indicated ith Client #3 in the living intervened. DSP #1 #3 hit her and she "took is on the couch." DSP #1 #3 started to kick and spit indicated she put her hand indicated when she got indi					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OI CORRECTION	15G504		LDING	00	06/14/	
		100007	B. WIN		DDDEGG GITTL GT TT COT	JU/ 14/	2010
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
IN-PACT	INC				LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` 1	ded a written statement					
	_	tion dated 5/21/13. The					
	`	DSP #2 and DSP #1 went					
	_	om to stop Client #3					
		e television. The QIDP					
		s in the living room when					
		#3 yelling. The QIDP					
		had kicked DSP #1 in					
		d she lost her temper."					
	`	ated DSP #2 was holding					
		OSP #1 was shoving					
	Client #3 which	resulted in all three of					
	them (DSP #3, D	OSP #1, and Client #3)					
	falling onto the c	couch. The QIDP					
	indicated Client	#3 was on the couch with					
	DSP #1 straddlin	ng him when she punched					
	him in the face w	which caused a "bloody					
	nose and bloody	lip." The QIDP					
	indicated DSP #3	l was yelling at Client #3					
	with her arm acre	oss his collar bone when					
	he spit in her fac	e. The QIDP indicated					
	DSP #1 grabbed	Client #3 by "his face,					
	squeezing hard a	and scratched his check					
	(sic) several time	es on the right side of his					
	nose." The QID	P indicated they (QIDP,					
	DSP #2, DSP #3	) were yelling at DSP #1					
	to stop. The QII	OP indicated DSP #3 was					
	holding onto Cli	ent #3 in an attempt to					
	prevent him fron	n attacking DSP #1, DSP					
	#2 was attempting	ng to get between Client					
	_	and she (QIDP) was					
		rying to get her off of					
		QIDP stated, "after about					
		OSP #1) released him					
	<u> </u>	-					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	A. BUII	LDING	NSTRUCTION  00	(X3) DATE COMPI <b>06/14</b>	LETED
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A 211 W 7	DDRESS, CITY, STATE, ZIP COD '6TH AVE LLVILLE, IN 46410	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
IAU	(Client #3), cont get her shoes on and [DSP #1] sta [DSP #4] had en time and grabbed her away and tel QIDP indicated In the investigation was substantiated were completed, indicated DSP # the investigation the allegation was on reporting and and allegations or received from the confirmed curren "consumers mus abuse by anyone limited to, facility consultants or votagency serving to members or legal other individuals."  2. On 6/10/13 at (Bureau of Deversives) reports	inued to yell and began to  [Client #3] swore at her arted to charge him again. tered the room at this d [DSP #1]'s arm, pulling ling her to 'just go'." The DSP #1 left the home.  on packet, the dicated, "This incident d and all investigations " The Administrator I was suspended pending and was terminated once as substantiated.  O4 PM, the facility policy investigating incidents of abuse and neglect was e QIDP (undated, nt) which indicated, t not be subjected to , including, but not y staff, other consumers, olunteers, staff of other the consumer, family I guardians, friends, or defined.  22:00 PM, the BDDS Ilopmental Disabilities from 6/10/12 to 6/10/13		TAU			DATE
		A BDDS report dated d on 5/21/13 Client #3					

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G504	A. BUII	LDING	00	COMPL 06/14/	ETED
		10001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/11/	2010
NAME OF P	PROVIDER OR SUPPLIER				76TH AVE		
IN-PACT	INC		MERRILLVILLE, IN 46410				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		cause he lost his outing		1710			BITTE
	_	plan." The report					
		#3 went into the living					
		"messing with the TV, as					
		o knock it over." The					
		DSP (Direct Service					
	•	and two other staff went					
	· ·	om to attempt to redirect					
		eport indicated DSP #1					
		e the TV alone. [Client					
		#1] in the knee and					
	-	r temper." The report					
	-	r staff attempted to move					
		the way but DSP #1					
		#3] and the other staff to					
		#1] hit [Client #3] in the					
	-	lient #3] spit in her face.					
	_	d [Client #3]'s face and					
		The report indicated three					
	-	and "got [DSP #1] off of					
		e report indicated DSP					
		quitting her job and left					
	the group home.	furthing her job und left					
	and Broap nome.						
	The BDDS repor	t indicated Client #3					
	sustained a "bloo	ody nose and lip along					
	with scratches or						
	shoulder/collarbo	one area." The report					
		#3's parents were					
		nose to file a police report					
		The report indicated DSP					
		d pending investigation					
	_	ted when the allegation of					
	abuse was substa	_					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			00	(X3) DATE COMPL	
		15G504		LDING	<del></del>	06/14/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				76TH AVE		
IN-PACT	INC				LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The OIDD amonic	1.1:					
		ded a written statement					
	_	tion dated 5/21/13. The					
	-	DSP #2 and DSP #1 went					
	_	om to stop Client #3					
	_	e television. The QIDP					
		s in the living room when					
		#3 yelling. The QIDP					
		had kicked DSP #1 in					
		d she lost her temper."					
	-	ated DSP #2 was holding					
		OSP #1 was shoving					
		resulted in all three of					
	` '	OSP #1, and Client #3)					
	_	couch. The QIDP					
	indicated Client	#3 was on the couch with					
	DSP #1 straddlin	ng him when she punched					
	him in the face w	which caused a "bloody					
	nose and bloody	lip." The QIDP					
	indicated DSP #1	l was yelling at Client #3					
	with her arm acre	oss his collar bone when					
	he spit in her fac	e. The QIDP indicated					
	DSP #1 grabbed	Client #3 by "his face,					
	squeezing hard a	nd scratched his check					
	(sic) several time	es on the right side of his					
	` '	P indicated they (QIDP,					
	-	) were yelling at DSP #1					
	· ·	OP indicated DSP #3 was					
	-	ent #3 in an attempt to					
	_	n attacking DSP #1, DSP					
	_	ng to get between Client					
	-	and she (QIDP) was					
		rying to get her off of					
		OIDP stated, "after about					
		,					l .

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/14	ETED
NAME OF F	PROVIDER OR SUPPLIER		211 W 7	DDRESS, CITY, STATE, ZIP CODE '6TH AVE LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	(Client #3), contiget her shoes on and [DSP #1] sta [DSP #4] had entime and grabbed her away and tell QIDP indicated. The investigation incident on 5/21. The investigation #3's mother filed 5/22/13 at 5:51 If On 6/10/13 at 2:0 on reporting and and allegations or reviewed by the confirmed current indicated, "In the situation requiring local Police Depimmediately not On 6/12/13 at 11 interviewed and not notify the police incident on 5/21, abuse by DSP #1 QIDP indicated; the incident and The QIDP indicated.	04 PM, the facility policy investigating incidents of abuse and neglect was QIDP (undated, nt). The facility policy e event of an emergency ng police assistance the artment is to be				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G504	B. WIN	G		06/14/	ZUT3
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					76TH AVE		
IN-PACT	INC			MEKKIL	_LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		nily was on the way and					
	-	le a police report. The					
	QIDP stated, "In hindsight, I can see why						
	we should have	called the police."					
	On 6/12/13 at 12	2:26 PM, the facility					
		ng crimes pursuant to the					
		t (undated, confirmed					
		) was reviewed. The					
		covered individuals					
	1 * *	rs, operators, employees,					
	· ·	s, and contractors) were					
		ort any reasonable					
		ime, as defined by the					
		against any individual					
		any type of services"					
	·	The policy indicated,					
		iving services did not					
		odily injury, the a					
	1	ual is required to report					
		later than twenty-four					
		forming the suspicion."					
	` ′	ated, "if a Covered					
		es In-Pact of its suspicion					
		st any individual who is					
	1	es from In-Pact, then					
	_	ort that suspicion to law					
		the Covered Individuals					
	behalf."	ine Covered marviduals					
	ociiaii.						
	3. On 6/12/13	at 12:16 PM, the facility					
		ng crimes pursuant to the					
	1	t was further reviewed.					
		ated, "it is In-Pact's					

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	DF CORRECTION IDENTIFICATION NUMBER:  15G504	A. BUILDING  B. WING	COMPLETED 06/14/2013
NAME OF I	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	policy to notify owners, operators, employees, managers, agents and contractors (collectively referred to as a 'Covered Individuals' and individually as 'Covered Individuals' of their duty to report reasonable suspicion of crimes to the Secretary and law enforcement." The policy indicated the facility, "shall take steps to ensure that Covered Individuals are notified annually of their duties to report under the Social Security Act. This may include, but is not limited to, one of the following ways" by posting the sign specified by the Secretary for this purpose in an appropriate location, in-service education, or staff meeting.  During an interview on 6/12/13 at 12:26 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated the facility did not have documentation which indicated staff had been trained on the Elder Justice Act. The QIDP indicated staff would have been trained during new hire orientation on facility policy and procedures. The QIDP stated the Elder Justice Act training would have occurred during a "broad discussion on policy and procedures" but otherwise no documentation was kept by the facility. No further training documentation for the Elder Justice Act was available for review.		

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Event ID: ZNQ211

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	LDING	NSTRUCTION  00	(X3) DATE COMPI 06/14	ETED
NAME OF F	PROVIDER OR SUPPLIER		STREET A 211 W 7	ODDRESS, CITY, STATE, ZIP CODE 76TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	E	(X5) COMPLETION DATE
	internal incident An incident report AM indicated Do the bath in the me bruise above the the size of a large indicated Client school yesterday called the school Client #3 "may be during the restration indicated the injuty source. The QII Disabilities Profesigned the incide On 6/10/13 at 2: of reporting and and allegations of received from the confirmed as cur indicated reportate event or occurrence or uncertainty re potential to result injury to an individual. Incide following: Unknown Origin	the 4:12 PM, the facility's reports were reviewed. For dated 11/30/12 at 6:15 SP #5 took Client #3 to acrack of his butt about the apple." DSP #5 #3 "had a take down at acrack of his butt about the apple." DSP #5 and they indicated the and they indicated the area gotten the bruise int." The incident report the arrow as of "known" DP (Qualified Intellectual the report on 12/21/12.  104 PM, the facility policy investigating incidents of abuse and neglect was the QIDP (undated, arrent). The policy lible incidents were "any the characterized by risk sulting in or having the attin significant harm or widual or death of an alents may include the #11. Injuries of an, #12 Significant injuries at limited to: a. Injuries				

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Event ID: ZNQ211

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G504				COMPLETED  06/14/2013			
		100004	B. WIN		DDDEGG CITY CTATE 7ID CODE	00/14/	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 76TH AVE		
IN-PACT	INC				LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	incurred while in	ndividual was					
	restrained" 7	The policy indicated					
	"upon the occurr	rence of any incident,					
	regardless of sev	erity, the staff who					
	observed the inci	ident/injury is to					
	immediately noti	ify the Program					
	Director/Admini	strator who will notify					
	the Program Mai	nager. Staff or day site					
	staff that was in contact with the						
	consumer during the previous 24 hours						
	will be interview	ed. Each staff will be					
	required to give a written statement of						
	their remembran	ce of events that occurred					
	for the consumer	during that time period.					
	The Program Ma	anager will be responsible					
	for gathering the	documentation from the					
	staff and getting	the documentation to the					
	Program Directo	r/Administrator within 5					
	days of the date	of the incident."					
	During an interv	iew on 6/12/13 at 11:37					
	,	ndicated the internal					
	•	were to be checked by					
		nanager and the QIDP.  I the bruise discovered on					
	,	P #5 was not reported to					
		or investigated as an					
		vn origin because it was					
	"just overlooked	."					
	9-3-2(a)						
	- \-'/						
							l

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Event ID: ZNQ211

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 4/2013		
NAME OF P	ROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP (	CODE			
IN-PACT	INC		211 W 76TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		

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Event ID: ZNQ211

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE : COMPL		
		15G504		LDING		06/14/	2013
			B. WIN		ADDRESS STATE AND CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE 76TH AVE		
IN-PACT	INC				LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	BROWNERS DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000153	483.420(d)(2)						
	_	ENT OF CLIENTS					
		ensure that all allegations neglect or abuse, as well as					
		vn source, are reported					
	-	e administrator or to other					
	•	ance with State law					
	through establish	ed procedures.					
			W0	00153	All staff are trained on		07/12/2013
		view and interview, the facility			abuse/neglect and reporting		
		njuries of unknown origin			policy upon hire and at least annually thereafter. Person		
	•	ediately to the administrator for			responsible: Ruth Fields, Train	nina	
	1 of 1 injury of unk	nown origin for 1 of 3 sampled			Coordinator. QMRP, Manager	•	
	clients (Client #3) ii	n accordance with state law.			and staff will be re-trained on		
	Findings include:				policy #28 reporting and investigating incidents of abus which includes immediately reporting unknown injuries.	se,	
		PM, the facility's internal			Responsible person: Sheila		
	_	re reviewed. An incident			O'Dell, Group Home Director.	Го	
	-	2 at 6:15 AM indicated DSP			ensure future compliance, all		
		the bath in the morning and			internal incident reports are to reviewed daily to ensure they	be	
		ove the crack of his butt about			were reported timely.		
		ople." DSP #5 indicated Client			Responsible person: Ingrid		
		n at school yesterday." DSP #5			Stringer-Bullard, Group Home		
		the school and they indicated			Manager. To ensure future		
	,	e gotten the bruise during the			compliance, a reliability will be completed to ensure compete		
		dent report indicated the injury			Responsible person: Traci	ncy.	
		urce. The QIDP (Qualified			Hardesty, QMRP.		
		ties Professional) reviewed			-		
	and signed the incid	lent report on 12/21/12.					
	During an interview	on 6/12/13 at 11:37 AM, the					
	· ·	internal incident reports were					
	-	th the house manager and the					
	•	tated the bruise discovered on					
		5 was not reported to the					
	-	injury of unknown origin					

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 15G504	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY  IPLETED  14/2013	
NAME OF		STREET ADDRESS, CITY, STATE, ZIP CODE  211 W 76TH AVE  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	because it was "just overlooked." 9-3-2(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G504			ULTIPLE CO LDING	00	(X3) DATE : COMPL 06/14/	ETED	
		15G504	B. WIN			06/14/	2013
NAME OF P	PROVIDER OR SUPPLIER			211 W	ADDRESS, CITY, STATE, ZIP CODE 76TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000154	The facility must be alleged violations investigated.  Based on record reversal failed to thoroughly unknown origin for injury of unknown of clients (Client # 3).  Findings include:  On 6/10/13 at 4:12 be incident reports were report dated 11/30/1 #5 took Client #3 too "noticed a bruise about the size of a large appearance of a large appearance of "known" sour indicated she called Client #3 "may have restraint." The incidents of "known" sour intellectual Disability and signed the incident puring an interview QIDP indicated the to be checked by bo QIDP. The QIDP so Client #3 by DSP #5	iew and interview, the facility investigate an injury of 1 of 1 incidents reviewed for origin for 1 of 3 sampled  PM, the facility's internal e reviewed. An incident 2 at 6:15 AM indicated DSP the bath in the morning and ove the crack of his butt about ople." DSP #5 indicated Client at school yesterday." DSP #5 the school and they indicated e gotten the bruise during the dent report indicated the injury arce. The QIDP (Qualified ties Professional) reviewed ent report on 12/21/12.  For on 6/12/13 at 11:37 AM, the internal incident reports were the house manager and the tated the bruise discovered on 5 was not reported or ujury of unknown origin	W0	00154	All staff are trained on abuse/neglect and reporting policy upon hire and at least annually thereafter. Person responsible: Ruth Fields, Trait Coordinator. All instances of unknown injuries are to be regimmediately and investigated thoroughly per policy. Responsible person: Sheila O'Dell, Group Home Director. QMRP and Manager will be re-trained on policy #28 report and investigating incidents of abuse, which includes completed a thorough investigation of an unknown injuries. Responsible person: Sheila O'Dell, Group Home Director.To ensure futur compliance, an investigation packet will be completed. The investigation packet will contains everything that is needed for a thorough investigation for unknown injuth This includes an assessment the injury, review of the incider report, communication with the consumer, review of the hous log and any other. It also includif medical intervention was needed and that all of the tear was contacted about the incider there is a section that they are	ting eting y e re ries. of ent aff, isual e ides m ent.	07/12/2013

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AND PLAN OF CORRECTION DESCRIPTION NUMBER: 15G504  NAME OF PROVIDER OR SUPPLIER IN-PACT INC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Check if it is substantia if the action taken appear of investigation packet is Program Director/Adm receives this packet will days of the incident an summery/assessment the the information is continued in the program Director/Adm receives this packet will day of the incident an summery/assessment the the information is continued by the presence of the program Director/Adm receives this packet will be program Director/Adm receives the program Director/Adm receives this packet will be program Director/Adm receives this packet will be program Director/Adm receives the program Director/Adm r	TRECTION HOULD BE APPROPRIATE  Ited or not, ears to be ction is shift Evels training, f the that the instrator
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Check if it is substantia if the action taken appear sufficient or if further an needed like: training, suchange, supervision le reestablished, BSP retect. The last section of investigation packet is Program Director/Adm receives this packet will days of the incident an summery/assessment the the information is continued in the gets passed off scheduled safety commeeting. Responsible	CODE  CRECTION HOULD BE APPROPRIATE  Atted or not, ears to be ction is shift Evels Erraining, f the that the instrator
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY)  TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY)  CHECK IF It is substantial if the action taken appear sufficient or if further an needed like: training, supervision le reestablished, BSP retent. The last section of investigation packet is Program Director/Adm receives this packet will days of the incident an summery/assessment the the information is continued in the program of the progr	TRECTION HOULD BE APPROPRIATE  Ited or not, ears to be ction is shift Evels training, f the that the instrator
IN-PACT INC    SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF COR (EACH OFFICENCY) MUST BE PRECEDED BY FULL   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   Check if it is substantial if the action taken appears sufficient or if further an eneeded like: training, so change, supervision le reestablished, BSP retet. The last section of investigation packet is Program Director/Adm receives this packet will days of the incident an summery/assessment the the information is continued to the program of the prog	TRECTION HOULD BE APPROPRIATE  Ited or not, ears to be ction is shift Evels training, f the that the instrator
IN-PACT INC  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Check if it is substantia if the action taken apper sufficient or if further an needed like: training, so change, supervision le reestablished, BSP ret etc. The last section of investigation packet is Program Director/Adm receives this packet wire days of the incident an summery/assessment the the information is coll then gets passed off scheduled safety commeeting. Responsible	APPROPRIATE  COMPLETION DATE  APPROPRIATE  COMPLETION DATE  COMPLETION DATE
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  Check if it is substantia if the action taken apper sufficient or if further an needed like: training, so change, supervision let reestablished, BSP ret etc. The last section of investigation packet is Program Director/Adm receives this packet will days of the incident an summery/assessment the the information is continued in the gets passed off scheduled safety commeeting. Responsible	APPROPRIATE  COMPLETION DATE  APPROPRIATE  COMPLETION DATE  COMPLETION DATE
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE ADEPICIENCY)  Check if it is substantial if the action taken appears sufficient or if further an needed like: training, sechange, supervision less reestablished, BSP retector. The last section of investigation packet is Program Director/Admireceives this packet will days of the incident an summery/assessment the the information is continued in the program of the pr	APPROPRIATE  COMPLETION DATE  APPROPRIATE  COMPLETION DATE  COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE ADEPICIENCY)  Check if it is substantial if the action taken appeared sufficient or if further an needed like: training, such ange, supervision letter. The last section of investigation packet is Program Director/Admireceives this packet will days of the incident and summery/assessment the the information is continued in the passion of the incident and summery/assessment the passion of the incident and	DATE  Ited or not, ears to be ction is shift evels training, f the that the instrator
check if it is substantia if the action taken apper sufficient or if further an needed like: training, suchange, supervision le reestablished, BSP retet. The last section of investigation packet is Program Director/Adm receives this packet with days of the incident an summery/assessment the the information is countried in the safety commeter	atted or not, ears to be ction is shift evels craining, f the that the instrator
if the action taken apper sufficient or if further and needed like: training, so change, supervision let reestablished, BSP ret etc. The last section of investigation packet is Program Director/Adm receives this packet with days of the incident and summery/assessment the the information is countried in the safety commetting. Responsible programs in the sufficient of the safety commetting. Responsible programs in the sufficient of the safety commetting. Responsible programs in the sufficient of the safety commetting. Responsible programs in the sufficient of the sufficient of the sufficient of the safety commetting. Responsible programs in the sufficient of the sufficien	ears to be ction is shift vels training, f the that the instrator
	nd a based off completed. to the next mittee person:

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G504		LDING	00	COMPLETED 06/14/2013	
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE 76TH AVE		
IN-PACT	INC				LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W000159	PROFESSIONAL Each client's active be integrated, coordinated a qualified mental.  Based on record reveloualified Intellectual (QIDP) failed to ensemble support Plan was in settings and monitor restraints at a school clients (Client #3).  Findings include:  On 6/10/13 at 4:12 Findings include:  "noticed a bruise about the size of a large appearance of a large appearance of a large appearance of the size of a large appearance of a large appearance of the size of a	retreatment program must ordinated and monitored by retardation professional.  iew and interview, the all Disabilities Professional pure each client's Behavior tegrated and coordinated in all red in regards to physical a setting for 1 of 3 sampled.  PM, the facility's internal ereviewed. An incident 2 at 6:15 AM indicated DSP the bath in the morning and over the crack of his butt about ople." DSP #5 indicated Client at school yesterday." DSP #5 the school and they indicated ergotten the bruise during the dent report indicated the injury rec. The QIDP (Qualified ties Professional) reviewed ent report on 12/21/12.  on 6/11/13 at 7:34 AM, DSP school usually called to fif if he had been restrained at whe might have a couple of any or two, but no bruises were indicated the house staff	W0	00159	The QMRP will be retrained to ensure that each client's day program is integrated, coordinated and monitored. Responsible person: Sheila O'Dell, Group Home Director. A form will be created to track ar monitor any restraints and sch suspensions. Responsible person: Traci Hardesty, QMRF To ensure future compliance, a day service contact will be completed as needed, but at le quarterly. Responsible person: Traci Hardesty, QMRP & Ingric Stringer-Bullard, Group Home Manager.	A nd ool P. a east	07/12/2013

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE COMPL	
ANDILAN	OF CORRECTION	15G504	A. BUI	LDING	00	06/14/	
		13G304	B. WIN			00/14/	2013
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
IN DACT	INC				76TH AVE		
IN-PACT	INC			WERRIL	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE AF		APPROPRIATE CONTINUE TO THE PROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILACI)		DATE
		ow slip to notify the supervisor					
	and would call to no	oury the guardian.					
	During on interview	on 6/11/13 at 11:37 AM with					
	_	dministrator, the QIDP					
		s restraints at school might be					
		mary of concerns in his ISP					
		Plan) or if necessary, extra					
	`	reld to discuss concerns. The					
	_						
Administrator indicated the facility usually received suspension notices for Client #3 if a							
restraint had occurred at school. The							
Administrator indicated the facility would not							
report or monitor restraints at a school setting the							
	same as the residential setting because the						
		different regulations. The					
		ated Client #3's behavior plans					
		resident settings were revised					
		vior Specialist. The					
		ated she believed the restraints					
		rial facility and the school were					
	similar in technique						
	similar in teeninque	out wasn't certain.					
	During record revie	w on 6/12/13 at 1:00 PM,					
		EP (Individual Education					
		/13 was reviewed. Client #3's					
	- '	oses, included but not limited					
	_	n defect hyperactive disorder),					
	oppositional defiant						
		rder, Tourette's Disorder,					
	-	d XYY syndrome. Client #3's					
		d a behavior plan which					
		s follows: physical aggression					
	_	s, knocking over desks,					
	, -	thers), negative verbal					
		· -					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		15G504	B. WIN	G		06/14/	2013
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	1110				76TH AVE		
IN-PACT	INC			MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		tions (e.g. using profanity,					
		ng), and problems maintaining					
		to include touching others.					
		cated when Client #3 "is					
		s emotions or has broken a					
	school rule, the grou	up home will be contacted to					
	pick [Client #3] up	from school. He will go home					
	to regain control and	d return the same day or the					
	next day." Client #	3's IEP included a Behavior					
	Intervention Plan (F	BIP) (undated) for Client #3.					
	Client #3's school B	SIP included a "Crisis					
	Contingency Plan"	which indicated "should					
	[Client #3] demonstrate a physically aggressive						
	behavior such that h	ne represents a risk to the safety					
	of himself or others	, security personnel will be					
	contacted. He may	also be placed in a safe					
	physical restraint us	sing CPI (crisis prevention					
	intervention) trained	d staff/techniques, but this					
	should only be done	e as a last resort."					
	During an interview	on 6/12/13 at 11:37 AM, the					
	QIDP indicated she	did not keep documentation of					
		restraints which occurred at					
		communicate such information					
		vioral Specialist. The QIDP					
		ncident report written by DSP					
		se discovered on Client #3 as a a reported physical restraint at					
		oked." The QIDP indicated the					
		ined copies of Client #3's					
	1	notices which were assumed to					
	involve physical res	straints to control behavior.					
	On (/12/12 + 12.24	DM Cliant #21 1 - 1					
		6 PM, Client #3's school					
	_	tion letters were reviewed. The					
		ion notification letters as					
		was suspended from school for					
	one day $(3/5/13)$ for	"physical aggression towards					
							l

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		LDING	NSTRUCTION 00	(X3) DATE COMPI <b>06/14</b>	LETED
NAME OF P	PROVIDER OR SUPPLIER		<u> </u>	211 W 7	DDRESS, CITY, STATE, ZIP CODE '6TH AVE LVILLE, IN 46410		
IN-PACT  (X4) ID  PREFIX  TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR staff and students," (5/17/13) for "physical verbal aggression and academics," and sure and 5/23/13) for "pl student." Client #3 notification letters of the interventions en behaviors on those of No further document review for physical	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) suspended for one day ical aggression towards staff, and disrupting school aspended for two days (5/22/13 hysical aggression towards a by school suspension did not include information on apployed during Client #3's dates. attation or data was available to restraints used to control a while he attended school.				BE	(X5) COMPLETION DATE

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G504	B. WING		06/14/2013
		l		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			76TH AVE	
IN-PACT	INC			LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W000189	483.430(e)(1)				
	STAFF TRAINING				
		provide each employee			
		ntinuing training that			
	·	oyee to perform his or her			
	duties effectively, competently.	eniciently, and			
	Competently.		W000189	All staff are trained ar	07/12/2013
	Dagad on interni	and record review that for illitar	W 000189	All staff are trained on abuse/neglect and reporting	0//12/2013
		and record review, the facility		policy upon hire and at least	
	-	ch employee with initial and evention and prohibition		annually thereafter. Responsit	ole
		s the employee to perform		person: Ruth Fields, Training	
		in regards to the facility's		Coordinator The Elder Justice	Act
		suspicions of abuse to the		is also posted at all locations i	
		outlined in the Elder Justice		common area in view.	
		potential to affect 4 of 4 clients		Responsible person: Ingrid	
		nome (Clients #1, #2, #3, and		Stringer-Bullard, Group Home	
	#4).	(		Manager.QMRP, Manager and	
	<i>,</i>			staff will be re-trained on polic	-
	Findings include:			#28 reporting and investigating	g
	Č			incidents of abuse, the Elder	
	On 6/10/13 at 2:00 l	PM, the BDDS (Bureau of		Justice Act in regards to notify the police. Responsible personant	_
	Developmental Disa	abilities Services) reports from		Sheila O'Dell, Group Home	1.
		were reviewed. A BDDS		Director. To ensure future	
		3 indicated on 5/21/13 Client		compliance, the training	
	_	cause he lost his outing per his		document will specifically state	e
		e report indicated Client #3		the Elder Justice Act to show	
	_	room and began "messing with		initial and continuing training to	
		going to knock it over." The		employees. Responsible perse	
		P (Direct Service Professional)		Ruth Fields, Training Coordina	ator.
		aff went into the living room to			
	_	Client #3. The report indicated			
		leave the TV alone. [Client			
		] in the knee and [DSP #1] lost eport indicated another staff			
	_	Client #3 out of the way but			
		lient #3] and the other staff to			
		hit [Client #3] in the face			
	-	spit in her face. [DSP #1]			
		's face and yelled at him." The			
		ee staff intervened and "got			
	Tr				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G504		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI <b>06/14</b>	ETED	
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC			B. WING GO/14/2013  STREET ADDRESS, CITY, STATE, ZIP CODE  211 W 76TH AVE  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR [DSP #1] off of [Cli	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Sent #3]." The report indicated		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
IAU	[DSP #1] off of [Clips DSP #1 said she was group home.  The BDDS report in "bloody nose and lipinght shoulder/collatindicated Client #3". "chose to file a politicated DSP investigation and was allegation of abuse. The QIDP provided investigation dated DSP #2 and DSP #1 stop Client #3 from QIDP indicated she she heard Client #3 Client #3 had kicked she lost her temper. was holding Client #3 Client #3 which rest #3, DSP #1, and Client #3 which rest #3, DSP #1, and Client #3 which rest #3, DSP #1 stradd him in the face which bloody lip." The Quyelling at Client #3 bone when he spit in indicated DSP #1 grade several times on the QIDP indicated they were yelling at DSP indicated DSP #3 was attempt to prevent here.	rent #3]." The report indicated is quitting her job and left the indicated Client #3 sustained a palong with scratches on the ribone area." The report is parents were informed and the report on his behalf." The P #1 was suspended pending as terminated when the		IAU			DATE
	trying to get her off	e (QIDP) was behind DSP #1 of Client #3. The QIDP 3 minutes, she (DSP #1)					

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AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:  15G504	A. BUI	BUILDING WING COMPLETED 06/14/2013		ETED	
NAME OF PROVIDER OR SUPPLIER				STREET A 211 W 7	DDRESS, CITY, STATE, ZIP CODE		
IN-PACT (X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			MERRILLVILLE, IN 46410  ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	began to get her sho and [DSP #1] started #4] had entered the EDSP #1]'s arm, pull 'just go'." The QID home.  The investigation pa 5/21/13 occurred at packet indicated Cli report on 5/22/13 at  On 6/10/13 at 2:04 I reporting and invest allegations of abuse the QIDP (undated, facility policy indicatemergency situation	es on. [Client #3] swore at her d to charge him again. [DSP room at this time and grabbed ling her away and telling her to P indicated DSP #1 left the acket indicated the incident on 2:15 PM. The investigation ent #3's mother filed a police 5:51 PM.  PM, the facility policy on igating incidents and and neglect was reviewed by confirmed current). The ated, "In the event of an arequiring police assistance the nent is to be immediately					
	notify the police reg of the suspected abu #3. The QIDP indic the incident and had QIDP indicated the police department b was on the way and report. The QIDP si why we should have On 6/12/13 at 12:26 reporting crimes pur (undated, confirmed reviewed. The polici individuals (known employees, manager	icated the facility did not arding the incident on 5/21/13 use by DSP #1 against Client rated she was present during a contacted the family. The facility did not notify the local recause she knew the family they elected to file a police rated, "In hindsight, I can see a called the police."  PM, the facility policy on resuant to the Elder Justice Act I current by QIDP) was					

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		IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION  A. BUILDING  00			COMPLETED  06/14/2013		
15G504		A. BUI B. WIN						
NAME OF I	DROVIDED OD SLIDDI IER				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			211 W 76TH AVE					
IN-PACT				<u> </u>	LLVILLE, IN 46410			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	of a crime, as define	ed by the laws of Indiana,						
		ual who is receiving any type of						
		acility. The policy indicated, ng services did not incur						
		ury, the Covered Individual is						
		ne suspicion no later than						
		urs after forming the						
		licy indicated, "if a Covered						
		n-Pact of its suspicion of a ndividual who is receiving						
		ct, then In-Pact will report that						
		forcement on the Covered						
	Individuals behalf."							
	On 6/12/13 at 12:1	6 PM, the facility policy on						
		rsuant to the Elder Justice Act						
		d. The policy indicated, "it is						
		notify owners, operators,						
		rs, agents and contractors d to as a 'Covered Individuals'						
		'Covered Individual') of their						
	I -	nable suspicion of crimes to						
		w enforcement." The policy						
		y, "shall take steps to ensure						
		duals are notified annually of tunder the Social Security						
		ude, but is not limited to, one						
	I	ys" by posting the sign						
		cretary for this purpose in an						
		, in-service education, or staff						
	meeting.							
		on 6/12/13 at 12:26 PM, the						
		tellectual Disabilities						
		ated the facility did not have						
		ch indicated staff working at rking with Client #1, #2, #3,						
		trained on the Elder Justice						
		icated staff would have been						
	1	hire orientation on facility						
	policy and procedur	res. The QIDP stated the Elder						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G504		A. BUILDING B. WING	00	COMPL 06/14/	ETED			
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE  211 W 76TH AVE  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REGULATORY OR LSC I	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE		
	REGULATORY OR LSC I  Justice Act training woul "broad discussion on pol- otherwise no documentat facility. No further staff	d have occurred during a icy and procedures" but ion was kept by the		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G504	(X2) MULTIPLE CO  A. BUILDING  B. WING	06/14/2013				
NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
W009999	State Findings  The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.  460 IAC 9-3-1(5)(b) Governing body Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.  This State Rule was not met as evidenced by:  Based on record review and interview, the facility failed for 3 of 9 internal incident reports reviewed involving 2 of 4 clients living in the facility (Clients #1 and #3) to submit reports in regards to falls with injury and physical restraint to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours. The facility failed for 2 of 91 behavior data sheet entries to submit report to BDDS within 24 hours in regards to physical restraints for 1 of 3 sampled clients (Client #3).  Findings include:	W009999	QMRP, manager and staff we retrained on the BDDS report requirements. Person responsible: Sheila O'Dell, Gr Home Director. To ensure fut compliance, reliabilities will be completed to show competen Responsible person: Traci Hardesty, QMRP. To ensure future compliance, all internal incident reports are to be reviewed daily to ensure they were reported timely. Responsible person: Ingrid Stringer-Bullard.	oup ure e cy.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G504		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL <b>06/14</b>	ETED		
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	from 6/1/12 to 6	ernal incidents reports /6/13 were reviewed on PM. The review indicated						
	- A incident report for Client #1 with an incident date of 1/14/13 indicated Client #1 tripped outside and injured his lip.							
	- A incident report for Client #1 dated 5/4/13 indicated Client #1 fell while running in the park and scraped his arm.							
	2/13/13 indicated	ort for Client #3 dated d Client #3's acne on the "was agitated during a aff."						
	dated 4/3/13 ind	a sheet entry for Client #3 icated Client #3 had two e to behaviors while in						
	dated 4/4/13 ind	a sheet entry for Client #3 icated Client #3 had a " due to "profanity and t (staff)."						
	AM, the QIDP (disabilities Profifs's restraints as incident reports	iew on 6/12/13 at 11:37 Qualified Intellectual essional) indicated Client documented in the and the behavior data hould have been reported						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G504		(X2) MULTIPLE CC A. BUILDING B. WING	00				
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  211 W 76TH AVE  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
IAG	to BDDS.  During an interview on 6/14/13 at 1:30 PM, the Administrator indicated the falls with injury were not reported to BDDS because the injuries were not of unknown origin.  9-3-1(5)(b)	IAG			DATE		

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